THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

September 7, 2010

Julius Genachowski, Chairman
Federal Communications Commission
445 12th Street, SW
8-B201
Washington, DC 20554

CC: 02-6

Dear Chairman Genachowski:

As the Federal Communications Commission (FCC) noted in its National Broadband Plan, widespread adoption and "meaningful use" of electronic health records (EHRs) will help transform our healthcare system. As such, the dissemination of EHRs is one of the principal goals of the current Administration and the Department of Health and Human Services (HHS). In 2009, the Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act (ARRA), allocating billions of dollars for our health care system to adopt and meaningfully use health information technology (HIT). Lacking the connectivity and resources available elsewhere, rural health care providers face particular challenges to being able to adopt electronic health records and exchange information, thus qualifying for the meaningful use incentives for health care providers that were authorized by that law.

I appreciate your active engagement in a discussion of these issues along with the Secretaries of Agriculture and Commerce and a representative of the Veteran's Administration on August 2, 2010. It was clear that there was much that we can do to resolve these issues by working together, and your ongoing help will make a big difference to rural health care providers.

At the August 2 meeting, you invited us to comment on the FCC's Notice of Proposed Rule Making on the Rural Health Care Support Mechanism. This letter conveys those comments as an attachment. We appreciate the opportunity to provide you with comments as we believe your regulation is a step in the right direction and offers a significant opportunity to both assist rural communities in acquiring and meaningfully using HIT and to align our two agencies' work so that the Administration realizes its important health care goals related to HIT. Our comments are geared towards making this alignment happen.

We encourage your agency to consider our comments about these programs in light of the exceptional demand placed on providers that will be working to achieve meaningful use. There is a common theme in our comments: during the planned stages of the meaningful use incentive program – through 2017 – HHS proposes that FCC strengthen its support of providers that are eligible for the incentive program. This includes increasing the subsidy rate of the Health Broadband Services Program to 90 percent for rural health care providers who qualify for HHS' meaningful use program and who are also eligible providers as defined by the FCC.

In addition, HHS recommends that FCC increases the maximum support to 100 percent under the infrastructure program to ensure that deployment of broadband service reaches those areas that need it the most.

This theme is founded on critical timing requirements. In July, the Department of Health and Human Services issued regulations which define the "meaningful use" objectives that providers must meet to qualify for the payments. The regulations are structured so that in the beginning, eligible providers are rewarded with extra incentives if they meet our requirements, for which they must exchange information electronically. For providers qualifying under the Medicare program, they must achieve meaningful use by 2012 to receive the full $44,000 available, and for those qualifying under Medicaid, the corresponding deadline is 2017. In order to become meaningful users, health care providers must have access to broadband. Eventually, according to the regulation now in force, Medicare eligible providers will be penalized financially if they fail to achieve meaningful use by 2015. Therefore, the access to broadband is imperative for them in the short term to have access to incentive payments and in the long term to avoid penalties.

We believe that it is important for all providers in all areas – rural, urban and suburban – to have the ability to qualify for meaningful use incentives. Unfortunately, there are large gaps to broadband access in rural areas. Indeed, broadband access is one of the biggest barriers to qualifying that rural health care providers face. The FCC's Notice of Proposed Rule Making can help close some of these gaps by increasing access to broadband in areas that do not have existing broadband infrastructure and assisting with sustainability over time. Our comments on your proposed regulation were made with those goals in mind and with the knowledge that rural providers need our and your assistance to be able to qualify for incentives.

Thank you for the opportunity to provide these comments. We greatly look forward to collaborating with the FCC on reforming its programs going forward.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

HHS Comments on FCC NPRM Rural Health Care Support Mechanism

HHS appreciates the opportunity to comment on the proposed rule which would implement key provisions from the National Broadband Plan released by the FCC in April. This proposal has the potential to address serious broadband capacity and connection issues facing rural health care providers. Ensuring access to broadband services is also a key element of the Administration's larger efforts to ensure that all health care providers become meaningful users of electronic health records.

Below are general and specific comments.

General Comment

Within the NPRM, the FCC did not address the issue of how to define rural areas; yet, the definition underlies the foundation of the NPRM. The FCC has relied on a hybrid definition of rural in its pilot program. HHS recommends the FCC adopt the HHS definition of rural currently used to determine eligibility for rural grant programs. This definition uses the Office of Management and Budget's county-based definition of metropolitan, micropolitan and non-core statistical areas. In addition, HHS rural programs also identify rural census tracts within metropolitan counties through the use of the Rural-Urban Commuting Areas (RUCA).

Specifically, we would recommend that rural areas include the following:

- Any micropolitan counties
- Non core-based statistical areas counties
- Census tracts classified as RUCA codes 4-10 in any metropolitan statistical area
- Census tracts classified as RUCA codes 2 and 3 if they are in census tracts that are in counties of 400 square miles or greater with a population density of 30 or less per square mile.

Specific Comments

For the purpose of presenting comments in response to questions posed within the FCC NPRM, HHS has provided the location of the comments by page number and paragraph number. In addition we have provided the specific comment in italics above HHS' response.

Page 9, Number 13

"Consistent with our authority under section 254(h)(2)(A) of the Act,31 we propose to create a "health infrastructure program" to fund up to 85 percent of eligible costs for the design, construction and deployment of dedicated broadband networks that connect public or non-profit health care providers in areas of the country where the existing broadband infrastructure is inadequate. The program would provide support for the construction of state or regional broadband health care networks that can, for example, connect rural and urban health care providers, facilitate the transmission of real time video, pictures, and graphics, bridge the silos that presently isolate relevant patient data,

make communications resources more robust and resilient, and maximize the efficiency and reliability of packet routing."

HHS recommends that federal health centers and Tribal/Urban Indian health facilities located in urban areas receive special consideration for participation both in the Health Infrastructure Program and in the Health Broadband Service program. These health care facilities face many of the same challenges encountered by rural facilities. Inclusion of such facilities will help demonstrate the value of investment in underserved urban communities, as a way of improving access to care and staffing recruitment/retention in these communities. Geography should not matter as much as need.

Page 11, Number 18
"The NPRM proposes that participants have a period of three funding years (commencing with the funding year in which the initial online application was submitted) to file all forms and supporting documents necessary to receive funding commitment letters from USAC; and a period of five years (commencing on the date on which the participant receives its first funding commitment letter for the project) in which to complete build-out."

The FCC should consider providing further explanation as to why three years was chosen to file all the forms and documents to receive the funding commitments. It has been reported that the Rural Health Care Pilot program featured situations in which the initial three-year requirement was exended to a fourth year. HHS recommends changing this requirement to five years so that lessons learned from the pilot program can be utilized. HHS also recommends changing the five-year buildout period to seven years to align with funding commitment letters.

Page 11, Number 20
"We seek comment on setting a minimum threshold for broadband connectivity speeds under the health infrastructure program. We seek comment on setting a minimum threshold for broadband connectivity speeds under the health infrastructure program."

HHS agrees with the standards established by the NPRM for connectivity speed of 10 Mbs and would like to emphasize these are only the base requirements necessary for effective health information exchange, and that the infrastructure program should support advancement of increased connectivity.

Pages 12-13, Number 22
"Because building a dedicated broadband network involves significant effort and costs, it is important to adopt a process that will ensure that projects are funded only in those regions where providers cannot obtain access to broadband adequate for health care purposes due to a lack of sufficient infrastructure. Three methods can be used by an applicant to demonstrate that adequate broadband is not available, including: certification that for a continuous period of not less than six months, the health care providers in the proposed dedicated network requested broadband services under the telecommunications program or the health broadband services program and did not

receive any proposals from qualified network vendors meeting their requested needs. We seek comment on whether six months is a sufficient period of time."

HHS suggests that the FCC provide further explanation for how it determined that the six-month threshold was appropriate including whether this number of months needs to be continuous.

Page 12-13. Number 22, Bullet 3

"Certify that, for a continuous period of not less than six months, the health care providers in the proposed dedicated network requested broadband services under the telecommunications program or the health broadband services program, and did not receive any proposals from qualified network vendors meeting the terms of the requested services. We propose six months as the minimum time period for which applicants must show that they were unable to acquire broadband services sufficient for their needs. This period would allow existing carriers to compete to provide services to the health care providers prior to any funding from the health infrastructure program. We seek comment on whether six months is a sufficient period of time. To the extent commenters propose other time periods, they should provide specific information to support their recommended time periods."

HHS recommends that language should be added to exempt federal health care providers which have telecommunication services provided under the GSA Networx contract. Federal health care providers such as IHS are contracted to purchases telecommunication services from the vendor selected during the fair-opportunity award under the Networx contract. A 6-month waiting period for vendor bidding is not appropriate for federal facilities that are required to use such contracts.

Page 13, Number 23

"The National Broadband Plan also suggested that health care providers could justify funding for an infrastructure program by providing a financial analysis showing that the cost of new network deployment would be significantly less expensive over a specified time period (e.g., 15-20 years) than purchasing services from an existing network carrier. We seek comment on whether we should adopt such criteria, in addition to the three options proposed above, and, if so, what should be included in the financial analysis? If we require that applicants demonstrate that network deployment would be less expensive over a period of time, what period of time is appropriate?"

HHS acknowledges the value of applicants demonstrating long-term cost savings. The challenge is how to balance this with concerns over administrative burden for small rural health care providers. FCC may want to consider providing additional guidance on a base level of financial analysis for all applicants so as not to disadvantage applicants without the resources to perform complex financial modeling and analysis. These projections are likely to be informed estimations given the dynamic nature of the telecommunications and health information technology sectors. As a result, the FCC may want to require a base level of financial information from all applicants in a manner that ensures a level playing field. Further, we encourage FCC to define "significantly less

expensive."

Page 14, Number 26

"We propose that as part of the initial application phase for infrastructure projects, applicants identify (1) all eligible health care providers on whose behalf funding is being sought, and (2) the lead entity that will be responsible for completing the application process. In addition, as in the Pilot Program, we would require that the application include a Letter of Agency (LOA) from each participating health care provider, confirming that the health care provider has agreed to participate in the applicant's proposed network, and authorizing the lead entity to act as the health care provider's agent for completing the application process. Such letters of agency will serve as confirmation that the identified health care providers endorse the proposed network, and will also avoid improper duplicate support for health care providers participating in multiple networks. All such letters of agency would be delivered by the applicant as part of the initial application."

HHS recommends that the "letter of agency" requirement be changed for federal facilities and organizations to a "letter of intent" requirement. One of the agencies within HHS experienced difficulty with the Pilot Program's "letter of agency." The letter proved confusing and time-consuming. In fact, because of misunderstandings concerning roles and responsibilities, it resulted in the discontinued participation of some facilities in a funded Pilot Program project. In this way, misunderstanding about organizational authorities and jurisdictions may be minimized while an emphasis on intended participation in regional consortia can be clear.

Page 15, Number 30

"Cap on Amount Funded Per Project: A per project cap would help ensure that multiple projects across varying unserved geographic areas will be eligible to receive funding for infrastructure. We note that nearly 90 percent of the projects in the Pilot Program had proposed budgets below $15 million. We seek comment on whether $15 million, or some other figure, is the correct per project cap to use."

While recognizing the desire to fund as many projects as possible (by using a per project cap), HHS recommends that a cap not be employed. This preserves flexibility, recognizes that market circumstances and situations vary from area to area and the FCC has not yet expended all of its funds

Page 15, Number 31

"Cap on Number of Projects per Year: We seek comment on whether to adopt a rule setting a maximum number of projects to be selected for funding each year. One of the lessons learned from the Pilot Program is that many applicants were ill-prepared to undertake the complex process of developing a new health care network, and consequently many required ongoing coaching and support to navigate their way through the process. A smaller number of projects will allow USAC to devote greater resources and time in ensuring their success. If the number of projects that apply and qualify for funding in any year exceeded such a cap, should priority be given to those projects that

connect the greatest number of rural health care providers."

HHS recently published a final rule implementing the provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. No. 111-5) that make incentive payments available to eligible providers participating in the Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified electronic health record (EHR) technology. 75 Fed. Reg. 44314 (July 28, 2010). Eligible providers under the Medicare program may qualify for these (voluntary) incentive payments over time, with a first payment year beginning in 2011, 2012, 2013, or 2014. and through 2017 for the Medicaid program. To qualify for these payments, eligible health care providers must be able to exchange health information electronically, among other requirements. Yet, in rural areas, the number of health care providers who can do so currently is limited. Thus, it is likely there will be heightened interest in FCC projects. HHS recommends that no cap be established before 2017 so that rural health care providers have an equal opportunity to qualify for incentive payments. If because of resource requirements a cap must be imposed, HHS recommends that rural health care providers who may be eligible to qualify for meaningful use incentive payments be exempt from the cap.

Page 16, Number 36
"While network design would be eligible for funding, the primary focus of the health infrastructure program should be capital costs for infrastructure construction and deployment. Therefore, we propose that support for eligible network design costs be limited to $1 million per project or 15 percent of the project's eligible costs, whichever is less. We seek comment on this proposal."

HHS recommends that there be no cap on support for network design, since the network's design can be critical to the success of the project and design costs can vary from project to project. While covering infrastructure costs is critical, the network design can be as important as infrastructure construction and deployment. We recommend that you consider more flexibility in how funds can be allocated among these three important areas.

Page 16, Number 37

"We propose that, for the health infrastructure program only, reasonable administrative expenses incurred by participants for completing the application process may be eligible for some limited support."

HHS believes that the FCC should allow support for administrative costs to be proportional to the support for other network activities, since administrative costs can be critical to a project's sustainability.

Page 17, Number 38
"Because the primary focus is to fund infrastructure and not project administration, we propose three limitations on administrative expenses: 1) support for such expenses is

limited to 36 months, commencing the month in which a participant has been notified that its project is eligible for funding, 2) rate of support will not exceed $100,000 per year which should be sufficient for one full-time employee, and 3) the aggregate amount of support a project may receive for administrative expenses shall not exceed ten percent of the total budget for the proposal. We seek comment on this proposal to provide limited support for administrative expenses."

Related to the time limitations, HHS recommends the FCC redefine the support for administrative expenses to five years or three years beyond buildout, whichever is greater. HHS recommends that FCC eliminate the second and third limitations. Rural health care providers often experience human capital shortages as well as a shortage of physical capital. With the nature of the operations of rural healthcare providers, HHS recommends the FCC remove the threshold of ten percent to support the project, as rural operating margins are historically inflexible and a ten percent threshold may be difficult maintain. HHS therefore recommends that maximum flexibility be maintained in these areas.

Page 17, Number 39

"Maintenance Costs: We propose allowing limited support for up to 85 percent of the reasonable, necessary and customary ongoing maintenance costs for networks funded by the health infrastructure program (e.g., service agreements to operate and maintain dedicated broadband facilities. We seek comment on whether support for maintenance costs should be limited to a defined period of time, such as three years from completion of build-out of a project, or five years from the first funding commitment letter issued for such project (whichever period is shorter)."

HHS recommends that FCC allow for maintenance for 11 years since this coincides with the period of time within which health care providers may qualify for meaningful use incentive payments and would help assure that rural providers have the same access to the payments as other (urban and suburban) providers.

Page 18, Number 40

"We propose that participants may receive support for not more than 85 percent of the membership fees for connecting their networks to the dedicated nationwide backbones, Internet2 or NLR. By connecting to either of these two dedicated national backbones, health care providers at the state and local levels could have the opportunity to benefit from advanced applications in continuing education and research. While the membership fees for joining NLR or Internet2 would be an eligible cost, we do not propose allowing other recurring costs related to connecting to such backbone networks. We seek comment on this proposal."

HHS recommends that, for providers who are eligible for meaningful use incentives, the FCC increase the maximum support to 100% for membership fees for connecting participant networks to either of the dedicated nationwide backbones. This level of support should continue through 2017 – the time period for health care providers to

qualify for meaningful use incentives. We recommend a reduced subsidy in subsequent years, which could be scaled down from 100%, to 80% to 50%, timed to coincide with the meaningful use requirements. We also encourage the FCC to consider whether it might want to continue the subsidy at a higher rate permanently for safety net providers. By increasing the support for these membership fees, the FCC NPRM would support the Administration efforts to increase the electronic exchange of health information and the use of the Nationwide Health Information Network.

Page 19, Number 42, Bullet 3
"We propose that, for the health infrastructure program, as in the Pilot Program, ineligible costs are those costs that are not directly associated with network design, construction, or deployment of a dedicated network for eligible health care providers."

The FCC may want to consider providing a capped amount of support for rural health networks' legal expenses. Rural health networks may not have in-house counsel and given the complex nature of developing the coalitions needed to successfully advance the kind of projects envisioned in this NPRM, the rural health networks may incur some related legal fees that are purchased on an as-needed retainer basis.

Page 20, Number 42, Bullet 13
"We propose that, for the health infrastructure program, as in the Pilot Program, ineligible costs are those costs that are not directly associated with network design, construction, or deployment of a dedicated network for eligible health care providers. We seek comment on this proposal. (Connections to ineligible network participants or sites (e.g., for-profit health care providers).)"

HHS encourages the FCC to explore its authority to allow for-profit entities to take part under current law and to align with FCC's defined eligible providers (not for profit providers). HHS' meaningful use regulations do not distinguish between for-profit and not-for profit health care providers. From an HHS perspective, there may be many acceptable reasons for not for profit providers to link with for profit providers in order to exchange health information. In rural areas, for profit providers may have very small margins and so allowing them to qualify for your programs would assist them and ultimately could help patients in rural communities, where there are sometimes very few providers (profit or not for profit) who delivery care. Thus, changing your definition and as well as allowing these costs might help all of these providers achieve meaningful use of electronic health records, an Administration priority.

Page 20, Number 44
"We propose that as one of the conditions to receiving any funding commitments from USAC, participants submit certification of the availability of funds, from eligible sources, for at least 15 percent of all eligible costs. We seek comment on this proposal."

HHS appreciates the need for FCC to vest participants by linking participation to a percentage contribution. HHS, however, believes that the required participant contributions should be tiered, with contributions ranging from zero to 5 percent. HHS

recommends no contribution, or a very low contribution for the following types of applicant: those in which a majority of the participating health care providers are in underserved areas, or in high poverty counties; key Federal safety-net providers such as Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Tribal and/or Federal Indian Health Service sites; or for those providers who are defined as being eligible for meaningful use incentives in HHS' final regulations. In addition, HHS recommends that if the matching requirement continues, the FCC allow applicants to consider as eligible costs in-kind cost participation broadly defined, such as devoting in-kind FTE support to the project or operating space or shared use of computer servers and equipment, and that for-profit providers' be allowed, since in rural areas these providers might naturally team up (because of the scarcity of providers there).

Page 21, Number 46

"We propose that, within 90 days after being notified of project selection, participants demonstrate that they have a reasonable and viable source for the minimum 15 percent contribution. We seek comment on this proposal."

As noted in the earlier comment, HHS believes the 15 percent threshold is too high. The FCC should also consider increasing the time allotted to demonstrating reasonable and viable funding for the project to 180 days.

Page 22, Number 47

"We propose placing limitations on the eligible sources for matching funds. Selected participants would be required to identify with specificity their source(s) of funding for the minimum 15 percent contribution of eligible network costs. Only funds from an eligible source may apply towards meeting this requirement. Ineligible sources would include (1) in-kind or implied contributions; (2) a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider; and (3) for-profit participants."

HHS recommends FCC re-evaluate its position on how it views in-kind contributions as eligible sources to meet the minimum contribution (see earlier comment).

Page 23, Number 50

Technology Neutral. While a project description must establish feasibility and scalability, we do not propose restricting the type of technology participants may use. Eligible health care providers participating in the health infrastructure program may choose any currently available technology that meets the definition of broadband as adopted for purposes of the Rural Health Care program. We seek comment on this proposal.

HHS believes that a technology neutral approach is valid. The technologies available for networking have dramatically changes in the last ten years, some emergent network technologies like Gigabit laser have had very little adoption, whereas other technologies

have had fad based wide support. By not limited the technologies for funding each organization can determine what meets their needs specifically.

Page 24, Number 54
"We seek comment on whether every project should be required to include ways in which the proposed network will be used in emergency response and meet disaster preparedness requirements."

HHS suggests the FCC also consider focusing on the need in rural areas for connectivity when emergency medical services are provided in nondisaster circumstances (e.g., having EHRs in use and exchange of data would improve patient care for nondiasaster emergencies). Connectivity under these circumstances is necessary due to the travel times between facilities in rural areas, as well as preparations necessitated to respond to a trauma event. This would also promote the use of broadband technology along a natural continuum of care.

Page 27, Number 59
"We seek comment on whether we should adopt rules that allow for the disposition of assets after the full economic useful life of funded projects (as determined, for example, under GAAP or as determined for tax depreciation reporting purposes). We also seek comment on whether the Commission should adopt rules that allow for the transfer of ownership of funded projects to subsidiaries or affiliates of the original applicants, provided that eligible health care providers continue to have a controlling beneficial ownership interest in the project."

This is an important issue. The passage of the Affordable Care Act has the potential to transform the way health care is delivered in the coming years, particularly related to demonstrations involving models such as value-based purchasing, Payment Bundling, and Accountable Care Organizations. These demonstrations could produce re-alignment of providers in ways that cannot be anticipated. As a result, the FCC should consider adding in flexibility that allows transfer of ownership to other entities as long as the overall goals of the proposed project remain the same.

Page 38, Number 93
"Pursuant to section 254(h)(2)(A), and consistent with the recommendations made in the National Broadband Plan, we propose to replace the existing internet access program with a new "health broadband services program," which will subsidize 50 percent of an eligible rural health care provider's recurring monthly costs for any advanced telecommunications and information services that provide point-to-point broadband connectivity, including Dedicated Internet Access. We seek comment on this proposal. We seek comment on whether an appropriate first step for expanding funding for broadband services should be to focus on rural areas, given the particular challenges that rural communities often face in obtaining access to health care."

HHS makes two recommendations. First, HHS recommends that there be a focus on rural areas since connectivity is more challenging there. Second, HHS recommends that

through 2017 the subsidy rate be 90 percent for rural health care providers who are eligible to qualify for HHS' meaningful use incentive payment program and who are also eligible providers as defined by the FCC. After 2017, Health Broadband Service participants' funding would revert to the subsidy level available to others. This would result in any providers that are receiving funding through the proposed FCC Health Broadband Service Program that are also eligible for meaningful use incentives receiving an extra subsidy off of their broadband costs; this is important for rural providers to be able to have needed support for broadband connectivity. Without access to broadband, rural providers may not be able to qualify for meaningful use incentive payments because they may not be able to exchange health information.

Page 39, Number 97

Would 4 Mbps be an appropriate minimum for purposes of the new health broadband services program, or should we require different minimum speeds depending on the type of health care provider? Four (4) Mbps could be a sufficient minimum requirement since the health broadband services program would be used to fund broadband services without funding additional infrastructure. In contrast, for the health infrastructure program, given the use of funding specifically for broadband deployment, the minimum broadband speed should be higher.

HHS asks why is there a need to specify a minimum? For broadband where the speeds may not be symmetrical in each direction, which direction is the proposed 4 Mbps intended? If a minimum has to be specified, consider a value which aligns with typical service provider service offerings. For example, 2 x T1 is 3Mbps.

Page 40, Number 98

"Eligible Service Providers. In the past, we have permitted health care providers to seek discounts on "the most cost-effective form of Internet access, regardless of the platform." Consistent with section 254(h)(2)(A),186 we propose that participants in the health broadband services program may seek supported services from any type of broadband provider, as long as the participant selects the most cost-effective option to meet its health care needs. We seek comment on this proposal."

HHS requests clarification on what FCC defines as cost-effective.

Page 40-41, Number 100

"Given the proposed availability of funding for infrastructure deployment and upgrades in the health infrastructure program, we propose placing limits on the use of funding under the health broadband services program for non-recurring costs. Under the internet access program, USAC allows participants to receive one-time support equal to 25 percent of the cost of Internet access installation. We propose that under the health broadband services program, participants may receive a one-time support equal to 50 percent of reasonable and customary installation charges for broadband access. We seek comment on this proposal."

Due to the lack of capital available to rural healthcare providers, HHS recommends the one-time non-recurring costs percentage be increased to 90 or 100 percent. The amount of the subsidy could be increased for applicants who are eligible for meaningful use incentive payments under HHS regulations, who are also eligible providers as defined by FCC.

Page 44, Number 110

Are there certain types of situations that should be exempted from the competitive bidding requirements?

HHS recommends that Federal health care providers using the GSA Networx contract for telecommunication services should be exempt from this requirement as a competitive (federally managed) bidding process has already taken place. Also, Federal agencies using the Networx contract are contracted to purchase from the vendor selected during the fair opportunity negotiations.

Page 44, Number 111

"Conversely, a health care provider who does not have an evergreen contract is considered to have a "month-to-month, tariffed service and must post an FCC Form 465 and select the most cost-effective service and service provider each year."

HHS recommends that health care providers using the GSA Networx contract for telecommunication services should have evergreen status and not have to re-new/re-bid each year.

Page 45, Number 115
"We seek comment below on several proposals to expand the specific facilities that can be funded, consistent with the current statute. We also seek comment on whether there are any providers not identified below that should be eligible for support, consistent with the provisions of section 254(h)(7)(B)."

HHS would welcome clarification about which other providers that might be eligible for support, consistent with the provisions of section 254(h)(7)(B). We are supportive of the broadest definition possible within the law.

Page 46, Number 116

"The National Broadband Plan recommended that the Commission expand its interpretation of eligible health care provider to allow participation in the Rural Health Care Support Mechanism by off-site administrative offices."

HHS concurs and suggests that the above recommendation be considered a high priority and supported under the new plan.

Page 49, Number 122

"As with the case of administrative offices, we note that off-site data centers can serve several purposes... As such, we propose to allow eligible health care providers to seek support only for off-site data centers in which the eligible health care provider has at least a 51 percent ownership or controlling interest. We also seek comment on whether an off-site administrative office that is less than 51 percent owned or controlled by an eligible health care provider would be eligible for support on a pro-rated basis or should be excluded from support altogether. ..We seek comment on these proposals."

HHS recommends that consideration be given to the scenario where the health care provider has 0% ownership in the off-site data center but hosts health care related equipment at the center. Eligibility should be considered where dedicated telecommunication circuits are provided to access the heath care related equipment – regardless of percentage of ownership.

Page 50, Number 125

"We seek comment on how to distinguish a facility that is primarily engaged in providing skilled nursing services as opposed to facilities that are primarily engaged in providing custodial care. For example, should we allow a facility to receive support as a skilled nursing facility if: (1) it has a certificate of need to provide skilled nursing services for at least 51percent of its total beds; or (2) at least 51 percent of the facility's revenues for the last twelve months are from skilled nursing services?"

The FCC's proposal for allowing participation of skilled nursing facilities using the 51-percent threshold is problematic in rural areas. While providing perhaps the only Medicare skilled nursing facility (SNF) services available in an area, the case mix in rural nursing facilities varies significantly and often necessitates that the facility must dedicate more beds to Medicaid and custodial patients than are needed for Medicare SNF services. HHS recommends that any Medicare Certified SNF (both free standing and distinct part units) be eligible and that no threshold for percent SNF beds be applied. In addition,the link to certificate of need (CON) is problematic since not all States still have this requirement. If the proposal from the FCC involves an applicant needing to meet at least one of the proposed requirements then this standard may be appropriate.

Page 51, Number 127

"Acute care provided by renal dialysis centers and renal dialysis facilities is consistent with the general schema of services traditionally provided by hospitals. We also believe that inclusion of renal dialysis centers and renal dialysis facilities is consistent with CMS's classification of these facilities. Additionally, we propose that a renal dialysis center or renal dialysis facility seeking rural health care support should be required to certify that, over the 12-month period preceding the date of application for support, the facility provided life-preserving ESRD treatment to at least 51 percent of its patients. We seek comment on the above proposals."

HHS concurs.

Page 51, Number 128-129

"The aggregate annual cap for the Rural Health Care Support Mechanism is $400 million. Given that current demand under the existing program has historically been less than $70 million, we see no need to revisit the overall funding cap. We do, however, believe it would be prudent to set an initial cap for the proposed health infrastructure program (within the overall $400 million cap) to manage the portion of funding that supports new deployment as opposed to ongoing services. We propose to allocate up to $100 million for infrastructure projects under the health infrastructure program, leaving at least $300 million available annually for the telecommunications program and the health broadband services program. We seek comment on this proposal to set $100 million cap for the health infrastructure program and $300 million for the telecommunications program and the health broadband services program."

HHS recommends maximum flexibility going forward through 2017 to dovetail with the timeframe for health care providers to qualify for the meaningful use incentive payments. We are concerned about a potential digital divide between rural and urban communities; the FCC program changes combined with the HITECH provisions offer the best mechanisms to protect against that but only if they are aligned and complementary. Our comments are aimed at assuring that they are aligned and complementary.

Page 52, Number 132

"One readily available source of information to prioritize funding requests would be to use HPSA scores. HPSA scores rank urban and rural geographic areas based on the shortage of primary care health professionals. We seek comment on the use of HPSA scores as a component of any prioritization considerations"

While HPSA scores may provide a method for prioritizing those areas of greatest need, using them would be problematic. A provision in the Affordable Care Act requires HHS to engage in a negotiated rulemaking process for revising the way it defines shortage areas, including both health professional shortage areas as well as Medically underserved areas and populations. That creates some degree of uncertainty about the definition of shortage areas over the next year or so. In addition, it is not clear how a collective HPSA score would be given to a potential applicant. For example, some applicants may represent service areas that include several counties which contain some areas that include designated HPSAs and some areas that are not HPSAs. How would the FCC score such an application? In addition, there are some HPSA designations that are facility based (for RHCs and FQHCs) but that do not necessarily have a score attached. How would that factor into an applicant's HPSA score for the purposes of this NPRM?

Alternatively, HHS recommends that through 2017 the rural health care providers who are eligible to qualify for HHS' meaningful use incentives under HHS regulations program and who are also eligible providers as defined by the FCC be given priority consideration. After 2017, Health Broadband Service participants would receive the same consideration as others. This would maximize the ability of providers to receive funding from the FCC when they need it most – as they are seeking to qualify for meaningful use incentives; this is important for rural providers to have needed support for

broadband connectivity. Without access to broadband, rural providers may not be able to qualify for meaningful use incentive payments because they may not be able to exchange health information.

Page 55-56, Number 142 and 143

"The National Broadband Plan recommended that the Commission align the Rural Health Care Support Mechanism with other federal government criteria intended to measure the efficient use of health IT, such as the "meaningful use" criteria being developed by HHS. Meaningful use criteria are intended to encourage physicians and hospitals to use broadband services and infrastructure in a way that improves the Nation's health care delivery system. HHS is still developing and considering regulations to implement meaningful use requirements for electronic health records, but is expected to adopt final rules later this year. Initially, under the HHS requirements, health care providers will be given financial incentives if they meet the HHS definition of meaningful use of electronic health records. In 2015, full Medicare and Medicaid support will be conditioned on compliance with meaningful use requirements, and health care providers will receive reduced Medicare or Medicaid reimbursement if they do not meet the requirements of meaningful use. We seek comment on whether and how the Commission could align its performance measures with HHS's meaningful use criteria. We also seek comment on whether there are other federal criteria that we should consider adopting."

HHS recommends that at this time the FCC should not align its performance measures with the meaningful use criteria and instead consider such linkage (such as 2015 for Medicare providers and 2017 for Medicaid providers, or later). HHS appreciates the FCC's intent to link to key health care activities. However, we believe the suggestions we have provided in our comments will better promote this alignment in the short term. Rural health care providers would benefit from access to the FCC's programs as they attempt to meet the meaningful use criteria; thus, our suggestions have focused on how that can be achieved in the short term. HHS is working toward ensuring that all eligible health care providers are able to meet the meaningful use standards by 2015 for Medicare and 2017 for Medicaid. However, some proportion of providers, particularly rural providers, may face challenges in meeting those requirements and we would not want to compound that problem by prohibiting their participation in this proposed program. HHS suggests the FCC align with the Medicaid segment which begins in 2011 and sunsets in 2017 to fully aid rural providers. The Medicaid model works towards adoption, implementation and upgrading of the technology.

The FCC may also want to consider other quality-focused administration initiatives. For example, there may be ways to tie participation in this program to providers reporting quality data to HHS as part of the various Medicare provider quality compare sites or the physician quality reporting initiative. HHS will work further with the FCC to assist in identifying useful ways to measure performance.

Page 56, Number 144

"We seek comment on whether, assuming full implementation of meaningful use requirements in 2015, recipients of funding from the Rural Health Care Support

Mechanism should be required to document their compliance with meaningful use requirements as a condition of receiving support. If the Commission were to adopt a meaningful use requirement, how should we evaluate whether the health care entity has satisfied meaningful use? We also seek comment on what should be the remedy for failure to meet such a requirement, if adopted? For instance, if a health care provider is required to comply with HHS meaningful use regulations as of 2015, should the Commission reduce or eliminate rural health care support if the entity has not achieved the HHS meaningful use standard by 2018?"

HHS concurs with this recommendation that the FCC reduce or eliminate rural health care support if the entity has not achieved the HHS meaningful use standard by 2017. Since there are many challenges associated with providing care in rural America, HHS recommends that rural health care providers have the maximum amount of time to meet the criteria under FCC's program. It would not be wise to reduce support for rural providers who have not attained meaningful use prior to 2017, because the absence of that support may be the reason for their failure to become meaningful users.